Aligned modern wellness

INTAKE

NAME ____ DATE ______________
ADDRESS________________________ CITY ________________ STATE _____ZIP_________
SEX • MALE • FEMALE BIRTH DATE_________ AGE _____ • SINGLE • MARRIED • DIVORCED • WIDOWED
SPOUSES NAME ________________
WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

HEIGHT_______ **WEIGHT**_____**BLOOD PRESSURE**_______**PREFERRED LANGUAGE** ________
RACE (circle one) UNSPECIFIED / AMERICAN INDIAN / ASIAN / BLACK OR AFRICAN AMERICAN / WHITE / OTHER RACE
ETHNICITY (circle one) UNSPECIFIED / HISPANIC OR LATINO / NOT HISPANIC OR LATINO
SMOKING STATUS (circle one) EVERY DAY SMOKER / OCCASIONAL SMOKER / FORMER SMOKER / NEVER SMOKED

ARE YOU EMPLOYED? Y OR N FULL-TIME OR PART TIME (circle one)
NAME OF EMPLOYER:____________________________OCCUPATION:________________
STUDENT? Y OR N FULL-TIME OR PART TIME (circle one)

SOCIAL SECURITY #:______________________

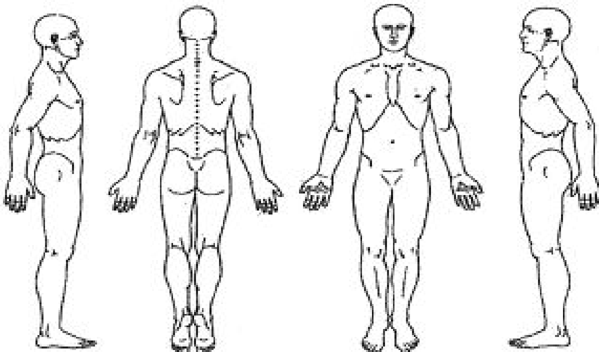
CONTACT INFORMATION

HOME PHONE _____________ CELL PHONE ______________ WORK PHONE ____________
EMAIL ____
EMERGENCY CONTACT NAME & # ____

PATIENT COMPLAINTS

Briefly describe your symptoms ____
____
How did your symptoms start? ____
____
Is this getting… • WORSE • IMPROVING • STAYING THE SAME **SEVERITY:** (NONE) 0…1…2…3…4…5…6…7…8…9…10 (SEVERE)
Type of pain • SHARP • ACHING/DULL • SHOOTING • NUMBNESS/TINGLING • CONSTANT • COMES & GOES
Limits my: • WORK • SLEEP • SITTING • STANDING • WALKING • BENDING • LYING • DAILY
How often do you experience your symptoms? • CONSTANTLY • FREQUENTLY • OCCASIONALLY • INTERMITTENTLY
How is your condition changing since care began at this facility:
• N/A, this is the initial visit • Much worse • Worse • A little worse • No change • A little better • Better • Much better

INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS BELOW:



FOR DR. USE ONLY:
ONSET ________________________
PAL/PROV ______________________
____
QUALITY ______________________
RADIATING ____________________
TIMING _______________________
SITE _________________________

Name:___________________________________ Date_______________

HEALTH HISTORY

What, if any, treatment have you already tried? ____

Have you had previous chiropractic care? If yes, name of doctor_____________________________________

Family Physician ____

CHECK YES OR NO TO INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING:

ABDOMINAL PAIN	__Yes __No	FRACTURES _______	__Yes __No	POLIO	**__Yes __No**
AIDS/HIV	__Yes __No	GALLBLADDER	__Yes __No	PROSTATE	**__Yes __No**
ALCOHOLISM	__Yes __No	GLAUCOMA	__Yes __No	PROSTHESIS	**__Yes __No**
ALLERGIES	__Yes __No	GONORRHEA	__Yes __No	PSYCHIATRIC	**__Yes __No**
ANEMIA	__Yes __No	GOUT	__Yes __No	RHEUMATOID ARTH	**__Yes __No**
ANOREXIA	__Yes __No	HEART DISEASE	__Yes __No	RHEUMATIC FEVER	**__Yes __No**
ANXIETY	__Yes __No	HEPATITIS	__Yes __No	SCARLET FEVER	**__Yes __No**
APPENDICITIS	__Yes __No	HERNIA	__Yes __No	SEIZURES	**__Yes __No**
ARTHRITIS	__Yes __No	HERNIATED DISC	__Yes __No	STROKE	**__Yes __No**
ASTHMA	__Yes __No	KIDNEY DISEASE	__Yes __No	TMJ	**__Yes __No**
BLEEDING	__Yes __No	LIVER DISEASE	__Yes __No	TUBERCULOSIS	**__Yes __No**
BRONCHITIS	__Yes __No	LUNG/RESPIRATORY	__Yes __No	TUMORS	**__Yes __No**
CANCER __________	__Yes __No	MEASLES	__Yes __No	TYPHOID FEVER	**__Yes __No**
CATARACTS	__Yes __No	MONO	__Yes __No	ULCERS	**__Yes __No**
CHEMICAL DEPENDENCY	__Yes __No	MS	__Yes __No	URINARY/BOWEL	**__Yes __No**
CHICKEN POX	__Yes __No	NUMBNESS	__Yes __No	VAGINAL INFECTION	**__Yes __No**
DEPRESSION	__Yes __No	OSTEOPOROSIS	__Yes __No	VENEREAL DISEASE	**__Yes __No**
DIABETES	__Yes __No	PACEMAKER	__Yes __No	WHOOPING COUGH	**__Yes __No**
EMPHYSEMA	__Yes __No	PARKINSON'S	__Yes __No		
EPILEPSY	__Yes __No	PNEUMONIA	__Yes __No		

OTHER ____

PLEASE LIST PAST INJURIES/SURGERIES **DATE**

____

____

____

CURRENT MEDICATIONS/MEDICATION ALLERGIES/VITAMINS/HERBS/MINERALS

____

____

____

DO YOU EXERCISE • NO • MODERATE • DAILY • HEAVY

GLASSES OF WATER PER DAY ______ **CARBONATED DRINKS PER DAY** ______ **ALCOHOLIC DRINKS PER WEEK** ______

MY STRESS LEVEL IS • LOW • MODERATE • HIGH • VERY HIGH

MY STRESS COMES FROM ____

ANYTHING ELSE WE SHOULD BE AWARE OF? ____

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www.alignedmodernwellness.com